

CONSENT TO MEDICAL TREATMENT AND WAIVER OF LIABILITY (VISITORS)

I,				, being an auth	norized visitor under
(Name)					
the Extended Family Visitor Program or othe		•	•	·	. , ,
years of age or older, do hereby give my con	sent a	nd autho	rize a l	epartment of Corrections'	health care provider to
provide emergency medical treatment (first a	id) or (other nor	-defini	ive primary care as may b	e necessary to prevent
pain, suffering, or prevent imminent threat to	my life	e, limb or	the fol	owing minor(s) as a result	of an emergency situation.
I have the authority to make medical decision	ns for t	he minor	(s) liste	d below,	
Minor(s)Name		Date of		e of Birth	
I hereby do waive, relinquish, and release are state of Washington, Department of Correction Department of Corrections accruing directly a such medical treatment which, in the discreti- dealing with an emergent health care problem	ons, th as a re on of t	e attendi sult of ea	ng hea ach trea	th care provider and all of tment, or as an indirect re	ficers and employees of the sult of the administration of
I do hereby further state that I have read the contents thereof, and that such consent to tr under any undue influence, threat, or coercid	eatme	•			•
Consenting Visitor Signature					Date
Subscribed and sworn to before me this _		d	ay of		20
STATE OF	_)				
)	SS.			
County of	_)				
				(Signature) NOTARY PUBLIC	
SEAL				Title	
				Printed Name	
				My Commission Expires	

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